Office of Statewide Health Planning and Development
California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
February 27, 2006

The meeting was called to order by Vito Genna, Chairperson, at 9:30 a.m., at the Four Points Sheraton Hotel at the Los Angeles airport.

Present:

William Brien, M.D.
Vito J. Genna, Chairperson
Howard L. Harris, Ph.D.
Sol Lizerbram, DO
Hugo Morris
Corinne Sanchez
Kenneth Tiratira, M.D.
William S. Weil, M.D.

Absent:

M. Bishop Bastien
Marjorie B. Fine, M.D.
Janet Greenfield
Jerry Royer, M.D., MBA

Staff: Kathleen Maestas, Acting Executive Director; Rebecca Markowich, Executive Assistant

OSHPD: David M. Carlisle, M.D., Ph.D., Director; Joseph Parker, Ph.D., Health Quality and Analysis Division; Michael Rodrian, Deputy Director, Healthcare Information Division; Jonathan Teague, Manager, Healthcare Information Resource Center; Charlene Parham, Healthcare Information Resource Center; and Starla Ledbetter, Patient Discharge Data Section

Also Present: Ronald L. Kaufman, M.D., MBA, Chief Medical Officer, Tenet

Chair's Report: At the last meeting, there was a presentation on the State's new method of paying for long-term care. Payment has now gone to a specific rate for each facility, based on cost reports collected by OSHPD. There is a problem with certain information in the reports, so the Department of Health Services is sending out a supplemental page to obtain more information. OSHPD and DHS have reached agreement on the data elements. The issue of adaptation to the computer system is still being worked out.

A publication from Price Waterhouse Coopers talked about the collision course from a global perspective of healthcare costs, giving 15 years before it will crash. The article also talks about how there should be a lot more sharing of healthcare information and other possible solutions..

Approval of Minutes: A motion was made, seconded and carried to approve the minutes from the December 12, 2005 meeting.

Health Data and Public Information Committee Report: Howard L. Harris, Committee Chair

Dr. Harris reported that the Health Data and Public Information Committee met on January 12. Because the Committee had not met for an extended period of time, the agenda consisted mostly of status reports. The Committee attempts to give balance to public information, which is consumer related, as well as other purposes, such as research. The presentations made were along those lines.

An update on implementation of changes in the reimbursement rate for long-term care was given. There was a preliminary report on the expansion of the discharge data set of 15 additional data elements and the criteria for selection of the data elements. Dr. Harris encouraged Commissioners to access the Committee minutes for more detail on the internet, www.oshpd.ca.gov, by clicking on "Boards and Commissions."

OSHPD Director's Report: David M. Carlisle, M.D., PhD, Director

The overall fiscal picture of the State is looking better. There is still a deficit within California State Government, despite increasing tax revenues.

OSHPD's budget has been expanded by $2.5 million with the addition of two significant new programs. The Song-Brown Program, the family practice training program, has been expanded to include the addition of a nurse training program. The Song-Brown Program basically encourages nursing schools to either add to their faculty or specifically increase the number of students that will be enrolled in nursing studies. This is part of the Governor's greater Nursing Workforce Initiative of the Department of Education.

The Data Fund is still supporting the Song-Brown Program. The former Song-Brown Program continues at the 50/50 percent funding level from the Data Fund. The Data Fund has provided support for the last three years, when it funded the program 100 percent because of budget deficits. The program was originally funded out of the State's General Fund. In the current budget, the level was reduced to a 50 percent support level. The family practice training program has historically supported physicians, physician assistants, and nurse practitioners.

A new program will be added to the Health Professions Education Foundation (Foundation) which supports scholarships and loan repayments to individuals, unlike the other Foundation programs that support institutions. The Steven M. Thompson Physician Scholarship and Loan Repayment Program was developed out of the Medical Board of the State of California, but is not compatible with the Medical Board's statutory activities. Once the program became successfully established, it was proposed that it be transferred to the Foundation, which was a recommendation approved in the Governor's Budget for the upcoming fiscal year. This program will encourage physicians to practice in under-served areas throughout the State.

Dr. Gary Gitnik, a faculty member of the School of Medicine at UCLA was recently appointed Chair of the Health Professions Education Foundation Board of Trustees. Dr. Gitnik has been a leader of various philanthropic activities in California. Robyn Boyer has been appointed Executive Director of the Health Professions Education Foundation. She is the former Deputy Chief of Staff for the Governor and brings experience in healthcare, specifically nursing issues, to the Foundation.

The first mandatory Coronary Artery Bypass Graft (CABG) report is moving toward release, as is the current issue of Perspectives.

OSHPD has received a report from the consultant at UCSF regarding the augmentation of the discharge data set. The consultant was charged with evaluating the addition of the data elements. Some of the data elements are clinical, consisting of patient vital signs, some are clinical laboratory elements, and others are demographic. The legislative mandate limits the augmentation to 15 data elements, but there are also variables that can be added outside that 15 limit, if they are already included in national standards.

There was much discussion by the Health Data and Public Information Committee about the elements, especially the clinical data elements. Dorel Harms of the California Hospital Association (CHA) said it would be very difficult for the hospitals to provide information such as that for the patients.

A preliminary report on the potential augmentation was first presented to the Technical Advisory Committee, and was just the beginning of many discussions on the subject. It was also presented to CHA's Hospital Quality Committee, which was attended by approximately 35 hospital representatives. There is a lot of movement nationally toward different collection systems, so the timing will be very important. ICD-10 coding is also on the horizon.

Update on Healthcare Information Division

Role of OSHPD in Current Activities on Emergency Preparedness: Michael Rodrian, Deputy Director, Healthcare Information Division, and Jonathan Teague, Manager, Healthcare Information Resource Center.

At the last meeting, there was a request for a presentation on the State of California's emergency preparedness. In the event of an actual public health emergency OSHPD would be in a supporting role to help the responsible agencies gather data.

The Department of Health Services has prepared a Pandemic, Influenza, Preparedness and Response Plan, about 170 pages long, which is available on the web at www.dhs.ca.gov .

The Federal Health Resources and Services Administration (HRSA), which provides funding to the states engaging in these kinds of emergency preparedness activities, requested information on surge capacity. The goal is to establish local response

capabilities and coordinate resources. OSHPD's role is to provide data, such as utilization and financial data, to assist federal, state and local government preparation for a mass casualty event. This would provide location of facilities, bed counts, workforce data, etc.

OSHPD has participated at meetings to provide information to planners to help brainstorm definitions which will be used, and to prepare a survey to send to hospitals.

In Sacramento, there is a community emergency response program which trains persons as first responders. HRSA said communities are supposed to look at resources as if they would be on their own without outside help. In the event of a natural catastrophe, such as earthquake or flood, communities might be cut off for an extended period of time. They wanted inpatient care and not emergency department capability in the planning exercise. There are complicated issues surrounding this effort such as emergency supplies of pharmaceuticals and how much to maintain, allocation of medicines, adult versus pediatric doses, etc. Obtaining qualified volunteers is an issue. An attack with nerve agents or botulism would require respiratory support and ventilators. Licensing requirements would probably be relaxed such as ratios of hospital personnel to patients and hospitals should be able to sustain care for a minimum of 72 hours. For planning purposes, it is assumed 30 percent of the hospital's personnel will not be available. There would be special needs for trauma and burn care.

DHS's pandemic response plan is an addendum to an existing public health emergency response plan. DHS would carry out the activities outlined in the plan, assisted by other agencies such as Health and Human Services Agency, Governor's Office of Emergency Services, and OSHPD. Local health departments are key to the plan, because they have the legal authority to take necessary steps in such an event. There will be a broad range of private sector partners and governmental entities involved.

The plan outlines in detail what the emergency management organization is, defines the concept of operations for pandemic response and outlines essential functions such as conducting surveillance, investigating cases and treatment, preventing the spread of an epidemic in the community, maintaining essential services and other activities. DHS's role is to protect and improve the health of all Californians and the overall goal of their emergency response plan is to reduce the mortality and morbidity and social and economic disruption that is associated with these kinds of events. DHS will provide leadership support and coordination in helping to mobilize whatever resources the State may have at its disposal. OSHPD will be working with the Federal Government when dealing with an epidemic. In the event of an earthquake, OSHPD would have a lead in assessing the workability and viability of healthcare facilities.

All State agencies have business continuity plans to continue providing services to the public to accomplish essential missions. The pandemic influenza plan will have a direct effect on how to develop and modify the business continuity plan. The Information Security Officer and other staff are working to update OSHPD's plan. The emergency response structure is already in place. All managers within OSHPD have copies of the business continuity plan, which contains procedures and phone contact numbers.

There will still be a need for services such as financial transactions for those dependent on payments from a government agency. Timely and accurate communication must be maintained and information given about protection of the public. OSHPD's collection systems are electronically based and there could be communication with hospitals using the MIRCal system, if the systems are running. OSHPD's data is backed up in accordance with State requirements, with off-site storage located out of the flood plain.

A key component of all plans is how to provide timely and accurate information to the public. One thought is to have a web portal with pertinent information in different languages, since California is a multi-lingual state. The Emergency Preparedness Office within DHS has been updated, using different multi-media connections, including short-wave radios to assist internal and external communications.

OSHPD has extended an invitation and EMSA has agreed to attend the next Commission meeting to discuss the statewide emergency preparedness effort.

There was some discussion about patient records being lost during a disaster and recovery of information. Nursing facilities are required to maintain a material data set (MDS) on patients, which is very detailed. This Federal program information is sent to Baltimore; where medical records for nursing facilities could be retrieved. There is no companion electronic piece, though, for acute care hospitals. All licensed facilities are required to have plans in place to protect medical records; DHS Licensing and Certification Program is required to see that these plans exist.

DHS is collecting information by way of a survey on "surge bed capacity", antibiotics available, number of ventilators, etc., to gain a comprehensive picture of what is available for a surge capacity response.

A major emergency should focus on community aggregation centers, community education, and appropriate triage from that site to hospitals.

OSHPD is the primary department for responding to emergencies that affect the structural integrity of hospitals. OSHPD's role is to participate in the discussions and to provide facility information relevant to the issues.

<u>Proposed Regulation Package</u>: Starla Ledbetter, Discharge Data Section

The proposed regulations have not been publicly noticed. Ms. Ledbetter reviewed the changes to the regulations.

97210 – Data submission, reminder notices, acceptance and rejection notifications, and extension information will be sent electronically.

97227, 97260, 97261 – Changes text to prevent over-reporting of external cause of injury codes (e-codes).

97240 – Adds a form to for "No Data to Report."

97241 – Eliminates giving a reason for use of extension days. Notices of approval and rejection of extension days will be e-mailed.

97244 – Updates the Manual Abstract Reporting Form to reflect changes to patient disposition codes.

97246 – Renames some forms and adds revision dates.

97250 – No report will be accepted if it is submitted more than 60 days after the prescribed due date.

97264 – Definition of data element for emergency department and ambulatory surgery disposition of patient.

97266 – Ongoing assessment fee of 50 cents for each encounter, based on final number of encounters in approved quarterly reports submitted by the facility during the previous calendar year.

Commissioner Morris asked about the penalty process for late submission of data and requested a periodic report. It was explained that with electronic submission, the reporting process is easier to submit information and, as a result, the number of penalties has been greatly reduced.

Motion was made, seconded and carried to move forward on the changes to the reporting requirements.

Update on Healthcare Information Resource Center Products: Jonathan Teague, Manager, HIRC and Charlene Parham, Healthcare Quality and Analysis Division
The mission of the Healthcare Information Resource Center is to support the Office's mission of equitable access to healthcare for all Californians. This is done by disseminating data in different ways. HIRC's role is strategic marketing and promotion, maintaining data confidentiality, product design and development, disseminating the information, and creating custom analyses. HIRC is always open to suggestions for ways to improve presentations and stay current with the technology of the data and dissemination. Most of the inquiries are from healthcare researchers and providers, press, media, legislative staff, and government agencies.

The databases deal with patient discharge data, utilization and financial data. The collection of patient level data is restricted to the hospital setting and ambulatory surgical data. This data is de-identified and aggregated to protect patient privacy. The utilization and financial data is available to the requestor. The information is available on the website, as are the outcome reports and annual reports to the Legislature.

Perspectives: Perspectives is a web publication which includes demographic information, by county or by State. The current version on the web uses 2000 data. The publication is consumer friendly and shows charts and graphs, trend lines, and comparisons to State level, etc. Each county, with the exception of Los Angeles and Orange Counties, consists of about 35 pages. Data for 2003 will be out shortly. There

is a lag time due to collection of the data by OSHPD and obtaining information from other sources.

It was suggested that HDPIC review the statewide summary in printed form and discuss the dissemination.

Top 25 DRG Pivot Table Products: The hospital charge masters were not very user friendly and did not provide the kind of information that the Legislature envisioned to be given to consumers. AB 1045 mandated reporting on diagnosis-related groups. A pivot table was developed to allow comparisons of hospitals. A demonstration was given on use of this pivot procedure. The top 25 DRGs change, depending upon how they are sorted such as by number of discharges, average charge per day, and average length of stay.

Discussion on Presumed Consent Policy for California: William S. Weil, M.D.
Dr. Weil was sent information on presumed consent which was distributed to the Commission. Presumed consent refers to organ donations. There are about 90,000 needs for organ transplants in this country, with only about 20,000 organs available every year. Currently, organ donation in the United States is optional. Several European countries, including most the Scandinavian countries, France, Austria, Belgium and Italy, have presumed consent procedures. The need for organ donations is alleviated in those countries where there is presumed consent in the event of a death and the organs are still viable. Unless a person says he does not want his organs removed or transplanted upon death, there is presumed consent.

Commissioner Morris made a motion, which was seconded and carried to place this item on the agenda for further discussion at the next meeting.

Other Business: Commissioner Morris had previously requested a discussion on the future of the Commission and outlined some of his thoughts in a letter to Dr. Carlisle. Some of the items related to publications formerly produced by OSHPD. A great deal of the data that was shared in these former publications are included in the Perspectives product available on the website now produced by OSHPD. The minutes from the last Health Data and Public Information Committee (HDPIC) go into great detail on some of the current activities of the Healthcare Information Resource Center. A motion was made, seconded and carried to add the discussion to the next Commission agenda.

Meeting Dates: The next Commission meeting will be held in Northern California on April 17, 2006. The next HDPIC meeting will be held on May 15.

Adjournment: The meeting adjourned at 2:05 p.m.

Pending Items:

1. Discussion on future of information dissemination by CHPDAC.
2. Discussion on Presumed Consent.
3. HDPIC review of Perspectives.
4. EMSA presentation on emergency preparedness.